Mental Health Services Act
Workforce Education and Training

Post-Secondary Education/Training Programs

Special Topic Workgroup

October 5, 2006

1. Present at workgroup meeting and/or teleconferences**.**

a. Jan Black, California Social Workers Educational Consortium
b. Sheila Boltz, California Association of Social Rehabilitation Agencies (CASRA)
c. Stephanie Clendenin, Office of Statewide Health Planning and Development (OSHPD)
d. Rosa Della Casa, Eastfield Ming Quong (EMQ)
e. Rick DeGette, Alameda County Vocational Programs
f. Wendy Desormeaux, Department of Mental Health
g. Robert McCarron, University of California at Davis, Department of Psychiatry
h. Dale Mueller, College of Health and Human Services, California State University at Dominguez Hills
i. Gigi Nordquist, California State University East Bay
j. Jesus Oliva, Mount San Antonio College
k. Beth Phoenix, University of California, San Francisco
l. Dina Redman, San Francisco State University, School of Social Work
m. John Ryan, California Mental Health Director's Association
n. Toni Tullys, Bay Area Workforce Collaboration
o. Inna Tysoe, Department of Mental Health (DMH)
p. Eduardo Vega, National Mental Health Association of Greater Los Angeles
q. Lesley Zwillinger, San Francisco State University, Rehabilitation Counseling

Chairperson: Warren Hayes, Department of Mental Health

2. Power Point Presentation (see attached)

The group reviewed a power point presentation that outlined the education and training actions endorsed for implementation and the results of the teleconference calls.

3. Review of teleconference minutes.

a. Funding post-secondary education programs.

The group discussed the use of MHSA education and training funds in two program areas:

(1). *Post-graduate residency and internship programs* that lead to licensure, specialization and/or preparation for working in public mental health. UC Davis's multidisciplinary setting, UCSF's Fresno extension campus, Kern County's psychiatric residency program, and the statewide Welcome Back programs were cited as models from which specifications, or a request for quotation, could be developed that would directly respond to public mental health workforce shortages for functional proficiency in such activities as prescribing and administering medication, and supervision of treatment plans.

The group also discussed various strategies that would provide financial incentives for both post-graduate programs and universities and public mental health employers to interchange faculty and employed licensed staff and provide sites where psychiatric residents and licensed interns can acquire supervised hours while working in public mental health. This would provide an increased number of psychiatrists committing to work in public mental health, and potential licensed professionals acquiring supervised hours while working in public mental health.

(2) *Paraprofessional certification programs* that lead to producing individuals proficient in delivering services according to the principles and practices intended by the Act. The Psychiatric Rehabilitation Certification Program (CPRP), Jump Start, and Welcome Back were cited as models from which specifications, or a request for quotation, could be developed for post-secondary institutions to directly respond to the level of public mental health need for trained professionals.

The group identified four broad academic levels for a psychosocial rehabilitation curriculum to be fielded: entry level, community colleges, bachelor's programs, and post-graduate programs. For the purposes of this specific workgroup the group focused on community colleges as a promising, receptive host for MHSA dollars to assist in establishing coursework and certification programs.

The above-cited programs will be contacted by DMH Education and Training staff for more detailed information on how their respective programs work, and obtain input on how MHSA funding could assist in establishing replicable model programs. The details of proposed programs could then be incorporated into a MHSA Education and Training regulations package and into Requests for Quotations. These programs, acting as replicable models, would need to add both an evaluative/research element as well as a consultative capacity to the rest of the state for facilitating growth of programs to the level of need. The group reinforced that any proposed programs have a sustainable funding source.

b. Continuing Education.

Use of MHSA education and training funds for the continuing education of existing employees was deemed important and appropriate in two areas:

(1) *For the Employee*. Payment for continuing education credits to educational/training entities recognized by licensing authorities. There was not a perceived need to create any additional CEU/CME structures. However, any proposed continuing education sponsored by MHSA would need to be consistent with the intent of the Act and meet workforce needs, such as language proficiency.

(2) *For the Employer.* Payment to employers (both county and contract agency) for release time to employees. An example would be a "20-20" strategy that would enable an employee to work part-time and attend education/training part-time. However, release time could be budgeted for a number of appropriate education and training functions, such as providing training and/or clinical supervision. The employer would be paid to hire additional staff time to fill behind the time that existing staff redirect to education and training activities.

A prominent unaddressed continuing education need was training mental health staff to be leaders, managers and administrators. Examples of topics could be personnel management, negotiating skills, skills and strategies in financial management, and using information to make better decisions.

c. Engaging faculty and employer/educator partnerships.

The group discussed how to engage faculty from post-secondary educational institutions in order to partner with county mental health programs and their contract agency staff in the major areas of teaching, internship supervision, conducting research, and providing service provision in community public mental health settings. This activity is happening, but only anecdotally, and primarily through the efforts of selected individuals who do not receive significant financial backing for their efforts.

Providing an ongoing regional partnership structure, as exemplified by the Greater Bay Area Regional Collaborative, will greatly facilitate partnership opportunities. However, judicious use of MHSA funds can operationalize and support relationships that will greatly benefit educational institutions in increasing their ability to prepare students according to the principles and practices intended by the Act, as well as provide valuable and immediate workforce help to county mental health programs.

Contracts, Memoranda of Understanding and Interagency Agreements between post-secondary education entities and county mental health programs and their contract agencies can provide contractual structure and funding to allow staff on both sides to redirect to each other's settings. Some examples would be teaching faculty receiving release time to provide service delivery and clinical

supervision at county mental health and contract agency sites, public mental staff and consumers and family members receiving release time and/or funding to assist with the teaching of courses at educational institutions, faculty staff partnering with public mental health programs to conduct research to develop evidence for emerging best practices, and licensed public mental health staff, via funding to backfill their time, providing dedicated time to create and staff internship experiences for students.

Funding could also promote faculty time at public mental health sites to provide valuable and immediate workforce help to county mental health programs, and public mental health staff on campus to co-teach, clinically supervise and assist in redesigning curricula. These activities would be determined, funded and administered at the local and regional level.

d. Supportive education.

The group discussed strategies for facilitating supportive education services in community colleges and universities in order to better assist individuals with consumer experience to have successful educational experiences. Although there are supportive education services, currently, they are generally two-track: academic and psychological with the psychological supportive services not normalized as part of the curriculum and often with many students wait-listed for the psychological supports. It was also pointed out that since there is not currently significant financial backing for supportive education, supportive education programs tend to be successful only if the education, mental health, and rehabilitation leadership is of high quality.

Providing an ongoing supportive education structure will greatly facilitate the educational efforts of students with psychiatric disabilities and the efforts of faculty to teach those students. It was suggested that, while every locality will have different needs and resources, a template demonstrating successful supportive educational programs and the challenges supportive educational programs could encounter would be useful. Some examples of successful programs that were mentioned included: normalizing supportive services to make it resemble an Employee Assistance Program (EAP) offered by most large employers; making psychological services part of the curriculum so that all students in the helping professions would have exposure to the types of supports available; building peer support into the curriculum or the educational structure; reaching out to persons with disabilities so they know about the supports available to them; coordinating supportive services so that both students and faculty know what to do; funding Disabled Student Programs and Services (DSPS) so they have the staff to train and supervise peer counselors and advisors; and a robust planning process that starts with employer's needs.

The issue of confidentiality/self-disclosure was mentioned as a potential challenge a supportive education program might face. It was also pointed out that successive budget cuts have forced many universities and community

colleges to significantly scale back their supportive education programs and that MHSA's prohibition on supplantation could be another barrier to funding supportive education. However, it was felt that judicious use of MHSA funds can assist in the building of successful supportive education programs that will greatly benefit educational institutions and students as well as provide valuable workforce help to county mental health programs.

It was also felt that front-end funds may be needed to bring county mental health and contract agency staff, post-secondary educational institutions and vocational rehabilitation agencies together to plan these programs. The group also endorsed the idea of replicable model programs as a consultative resource for further supportive education resources to be established.

4. Next Steps.

The group discussed principles and standards to be included in Request for Quotations in the above post-secondary areas. Upon resolution of funding and governance issues the Department will embark upon making MHSA funding available. Specifically, how much funding is to be made available in this area, which programs will be funded and administered at the state and/or county level, and funding structures to sustain successful programs over time.